

35 Renal Dialysis Facility

End Stage Renal Disease (ESRD) services are outpatient maintenance services provided by a freestanding ESRD facility or hospital-based renal dialysis center.

The policy provisions for Renal Dialysis Facility providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 24.

35.1 Enrollment

EDS enrolls Renal Dialysis Facility providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a Renal Dialysis Facility provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for dialysis-related claims.

NOTE:

All eight characters are required when filing a claim.

Renal Dialysis Facility providers are assigned a provider type of 34 (Renal Dialysis Facility). The valid specialty for Renal Dialysis Facility providers is Hemodialysis (H5).

Enrollment Policy for Renal Dialysis Facility Providers

To participate in Medicaid, End Stage Renal Disease (ESRD) facilities/centers must meet the following requirements:

- Certification for participation in the Title XVIII Medicare Program
- Approval by the appropriate licensing authority

Satellites and sub-units of facilities or centers must be separately approved and contracted with Medicaid.

35.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Medicaid covers maintenance dialysis treatments when they are provided by a Medicaid-enrolled hospital-based renal dialysis center or a freestanding ESRD facility. The maintenance dialysis treatments do not count against the routine outpatient visit limit.

Hemodialysis is limited to 156 sessions per year, which provides three sessions per week.

Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuing Cycling Peritoneal Dialysis (CCPD) are furnished on a continuous basis, not in discrete sessions, and will be paid a daily rate, not on a per treatment basis. Providers are to report the number of days in the units field on the claim.

The daily IPD or CAPD/CCPD payment does not depend upon the number of exchanges of dialysate fluid per day (typically 3-5) or the actual number of days per week that the patient undergoes dialysis. The daily rate is based on the equivalency of one week of IPD or CAPD/CCPD to one week of hemodialysis, regardless of the actual number of dialysis days or exchanges in that week.

Reimbursement will be based on a composite rate consisting of the following elements of dialysis treatment:

- Overhead costs
- Personnel services, such as administrative services, registered nurse, licensed practical nurse, technician, social worker, and dietician
- Equipment and supplies
- Use of a dialysis machine
- Maintenance of the dialysis machine
- ESRD-related laboratory tests
- Biologicals and certain injectable drugs, such as heparin and its antidote

NOTE:

Dialysis facilities that have a physician who performs EKGs on-site can apply for a physician provider number that will pay to the facility. The CPT-4 procedure codes for EKG tracing and interpretation may be billed using the physician provider number on the CMS-1500 claim form.

Laboratory Services

Laboratory tests listed below are considered routine and are included as part of the composite rate of reimbursement. All other medically necessary lab tests are considered nonroutine and must be billed directly by the actual provider of service.

Deleted:
Ultrafiltration is
limited...per
year.

Hemodialysis

The following table lists Hemodialysis tests and frequency of coverage:

Frequency	Covered Tests
Per treatment	All hematocrit and clotting time tests furnished incidentally to dialysis treatments.
Weekly	Prothrombin time for patients on anticoagulant therapy; serum creatinine, BUN.
Monthly	Alkaline Phosphates LDH Serum Biocarbonate Serum Calcium Serum Chloride Serum Phosphorous Serum Potassium SGOT Total Protein

Continuous Ambulatory Peritoneal Dialysis (CAPD)

The following table lists CAPD tests and frequency of coverage.

Frequency	Covered Tests	
Monthly	BUN	Total Protein
	Creatinine	Albumin
	Sodium	Alkaline Phosphatase
	Potassium	LDH
	CO2	SGOT
	Calcium	HCT
	Magnesium	Hgb
	Phosphate	Dialysis Protein

All laboratory testing sites providing services to Medicaid recipients, either directly by provider or through contract, must be certified by Clinical Laboratory Improvement Amendments (CLIA) that they provide the required level of complexity for testing. Providers are responsible for assuring Medicaid that they strictly adhere to all CLIA regulations and for providing Medicaid waiver certification numbers as applicable.

Laboratories that do not meet CLIA certification standards are not eligible for reimbursement for laboratory services from Medicaid.

Ancillary Services

The actual provider of services must bill take home drugs that are medically necessary under the pharmacy program.

Routine parenteral items are included in the facility composite rate and may not be billed separately. This includes medications and supplies used in providing intradialytic parenteral nutrition (IDPN).

Non-routine injectables administered by the facility may be billed by the facility actually providing this service. Non-routine injectables are defined as those given to improve an acute condition such as arrhythmia or infection.

Added: This includes medications... parenteral nutrition (IDPN).

Routine drugs or injectables administered in conjunction with dialysis procedures are included in the facility's composite rate and shall not be billed separately. These include but are not limited to the following:

- Heparin
- Glucose
- Protamine
- Dextrose
- Mannitol
- Antiarrhythmics
- Saline
- Antihistamines
- Pressor drugs
- Antihypertensives

The administration fee for injectables is included in the facility's composite rate for dialysis and must not be billed separately under a physician provider number.

The following procedures are non-routine and must be billed by the actual provider of service:

<i>Procedure Code</i>	<i>Description/Limits</i>
76061	Bone Survey - annually (roentgenographic method or photon absorptometric procedure for bone mineral analysis)
71020	Chest X-ray - every six months
95900	Nerve Conductor Velocity Test (Peroneal NCV) - every three months
93000	EKG - every three months

Physician Services

Physician services rendered to each outpatient maintenance dialysis patient provided during a full month shall be billed on a monthly capitation basis using the appropriate procedure code by age as outlined in the CPT. Monthly maintenance dialysis payment (i.e., uninterrupted maintenance dialysis) is comprehensive and covers most of a physician's services whether a patient dialyzes at home or in an approved ESRD outpatient facility. Dialysis procedures are allowed in addition to the monthly maintenance dialysis payment. In general, the Agency follows Medicare guidelines related to monthly capitation payments for physicians.

Physician services included in the monthly capitation payment for ESRD related services include, but are not limited to:

- Assessment and determination of the need for outpatient chronic dialysis therapy
- Assessment and determination of the type of dialysis access and dialyzing cycle,
- Management of the dialysis visits including outpatient visits for evaluation and management, management during the dialysis, and telephone calls.

- Assessment and determination if a recipient meets preliminary criteria as a renal transplant candidate including discussions with family members
- Assessment for a specified diet and nutritional supplementation for the control of chronic renal failure, including specifying quantity of total protein, sodium, potassium, amount of fluids, types of anemia and appropriate treatments, type of arthropathy or neuropathy and appropriate treatment or referral, estimated ideal dry weight, etc. Assessment for diabetic patient's diet and caloric intake is included also.
- Prescribing the parameters of intradialytic management including anticoagulant, dialysis blood flow rates and temperature, duration and frequency of treatments, etc.

The monthly capitation payment is limited to once per month, per recipient, per provider.

The following services are not covered by the monthly capitation payment (MCP) for the attending dialysis physicians and are reimbursed in accordance with usual and customary charge rules:

- Dec clotting of shunts
- Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these service, For example, an attending physician who provides evaluation and management (E&M) services for a renal patient in an inpatient setting may bill appropriate CPT hemodialysis procedures in lieu of certain other E&M services for inpatient visits.
- Nonrenal related physician services furnished by the physician providing renal care or by another physician. (These services may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.) For example, physician services rendered to hospitalized inpatient recipients who require dialysis but are not receiving dialysis on that day, may use the appropriate procedure code as described in the CPT.

Physician services are allowed for outpatient maintenance dialysis patients not performed as prescribed during a full month or interruptedly. An example of interrupted monthly outpatient dialysis maintenance is preceding and/or following the period of hospitalization.

The CPT codes described by age for physicians rendering outpatient dialysis services that are interrupted during a full month should be billed on a per day basis. These codes should be billed for the days of the month in which the outpatient ESRD related services were performed.

Single or repeated physician assessments are allowed for hemodialysis or dialysis procedures other than hemodialysis. These services are comprehensive and include assessment and management related to the patient's renal dialysis. Please utilize the most descriptive and appropriate CPT dialysis procedure when billing for single or repeated physician evaluation(s).

Dialysis training is a covered service when billed by an approved ESRD facility.

35.3 Prior Authorization and Referral Requirements

Dialysis procedure codes generally do not require prior authorization. Any service that is warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

35.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Renal Dialysis Facility providers.

35.5 Completing the Claim Form

➤ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Renal Dialysis Facility providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-92 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

35.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Renal Dialysis Facilities to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

35.5.2 *Diagnosis Codes*

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists Medicaid required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

35.5.3 *Procedure Codes, Revenue Codes, and Modifiers*

The (837) Professional and Institutional electronic claims and the paper claims have been modified to accept up to four Procedure Code Modifiers.

Renal Dialysis Facility providers are limited to the following codes:

<i>Revenue Code</i>	<i>Procedure Code</i>	<i>Description</i>
821	90935	Hemodialysis procedure with single physician evaluation. Limited to 156 units per year.
821	90937	Hemodialysis procedure requiring repeated evaluations with or without substantial revision of dialysis prescription. Limited to 156 units per year.
831 841	90945	Dialysis procedure other than hemodialysis (e.g. peritoneal, hemofiltration) with single physician evaluation. Limited to 156 units per year.
831 851	90947	Dialysis procedure other than hemodialysis (e. g. peritoneal, hemofiltration) requiring repeated evaluations with or without substantial revision of dialysis prescription. Limited to 156 units per year.
831	90989	Dialysis training, patient, including helper. Limited to 12 units per lifetime.
250	Q4055	Injection of Epogen
250	Injectable Codes	See Alabama Medicaid Injectable Drug Listing in Appendix H for covered injectable drugs.

35.5.4 *Place of Service Codes*

Place of service codes do not apply when filing the UB-92 claim form.

35.5.5 *Required Attachments*

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

35.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N